mitted to their managed-care programs in other states.

In other cases, managed care plans have continued to cover Medicaid and Medicare recipients but have dropped benefits that they once used to lure clients. In January, none of Maryland's nine HMOs in the HealthChoice program, a state-operated health care program that channels Medicaid recipients into HMOs, passed the state's test for "adequacy of care" for diabetics and new enrollees, who were supposed to be examined within 90 days of signing up. Screening for substance misuse was virtually nonexistent, and it was difficult to tell from records whether patients even had primary care doctors assigned to them.

So far, in California, the commercial HMOs have not defected from the state's Medicaid managed care programs, according to Jamie Tyre, director of business development and marketing at the San Francisco Health Plan. Some plans have recently begun grumbling that they may soon leave, however, according to Jim Lott, executive vice president of the Healthcare Association of Southern California.

Managed care plans are disappointed that they can no longer expect windfalls from insuring Medicaid beneficiaries, and state governments are disappointed that HMOs may not be able to help curtail the rising cost of insuring Medicare and Medicaid recipients.

"Right now, California still is a market with an abundance of providers," Lott said. "So even though capitated payments are 30% less than what they should be, health plans are still able to exact large discounts from hospitals. If that changes, the plans could face more pressure."

Heralding a change in the California market, the state has recently mandated that increases in capitation rates be passed on directly to providers. "Before this decision, that extra money would usually evaporate somewhere at the health plan level," Lott said. Managed care plans are disappointed that they can no longer expect windfalls from insuring Medicaid beneficiaries, and state governments are disappointed that HMOs may not be able to help curtail the rising cost of insuring Medicare and Medicaid recipients. It seems unlikely that the trend to pull out will be reversed.

Blue Cross/Blue Shield of Texas said last month that it will not join the state's Medicaid managed-care program in the busy Dallas area because of what the insurer calls unreasonably low reimbursement rates. "All we were asking for was a break-even on this business, and we were projecting anywhere from a half-million to a $2 million loss," said David Bick, Blue Cross' vice president of government programs.

COMMENTARY

Cost controls must not damage quality

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The recent exit of managed care health plans from Medicare and Medicaid markets around the country has stimulated heated discussions about the commitment and viability of commercial plan participation in these two government programs. Critics claim that the money-hungry plans have taken their profits and are now abandoning seniors and poor people. Federal and state officials deny that the exits portend challenges or trouble within the programs, citing them as minor setbacks. We will argue that the truth lies somewhere in the middle and aim to point out key concerns and areas where further research is needed.

First, let us begin with the original objective that publicly funded health programs hoped to achieve through the introduction of managed care. Governments implemented managed care in Medicare and Medicaid to provide beneficiaries with increased options for access to quality health care at more affordable prices than in the traditional fee-for-service programs.

There are a number of elements essential to attaining this goal: (1) health plans must continually realize a compelling business case for participation in the programs, (2) beneficiaries must find a compelling reason to enroll in managed care plans or to select one plan over another, and (3) costs must be controlled. It was hoped that managed care plans could do in the public sector what they had shown possible in the private sector: control costs while (arguably to some) maintaining quality.

Use of market mechanisms to improve access and control costs requires acknowledging some of the realities of how markets function. Entry and exit is a natural part of properly functioning markets. The question should not be whether exits will occur, but why plans are leaving and the extent to which beneficiaries are affected.

Although some plans say they are exiting markets because of inadequate rates and burdensome regulations, there may be additional reasons. Some plans entered markets late and found they couldn't build enough market share to make the business viable. Other plans may have failed to develop the expertise

needed to make the programs work. The important questions are whether a sufficient number of high-quality plans remain in the market to achieve the goals of the programs and whether the level of instability presents an unacceptable level of disruption in patients' care.

In order for the managed care marketplace to work, it must also be financially viable for physicians. If premiums are too low, physicians will be unable or unwilling to participate in the program. There are signs that payments to physicians may be too low in some places.

Some physicians, particularly in California, where physician payments are relatively low, say they are teetering on the edge of financial inviability. As one factor influencing plans' decisions to leave markets, plans cite resistance from physicians who are holding the line against rates they say are too low to deliver quality care. Other plans are reconfiguring their networks to exclude, where possible, physicians who demand higher payments. Instability among physicians participating in the programs may cause greater disruption of patient care than the exit of health plans.

Finally, there are powerful forces causing medical costs to increase every year. The major drivers toward cost increases are the development of expensive new technology, pharmaceuticals, and the aging population. Payments to plans and physicians need to keep pace with some of these dramatic increases in medical costs. Yet federal and state budget decisions frequently have more impact on rates than do business decisions based on program costs.

For the Medicare program, the Balanced Budget Act of 1997 established a 2% cap on health plan payment increases at a time when medical costs were projected to rise 6% a year. Risk adjustment, scheduled to start in the year 2000, has added uncertainty to the question of future rates. This raises the question of whether rates will be adequate to support the business case for plans to participate in the program and what changes plans may make in order to stay in the program.

In the Medicaid program, federal guidelines impose an 'upper payment limit' that prevents states from paying more for managed health care than they would have paid under fee-for-service. In California, where fee-for-service rates were low prior to the implementation of managed care, health plan capitation rates are currently the lowest in the nation. Physicians and plans complain about these low rates which, prior to 1998, had not been increased significantly in more than a decade. Admittedly, states must be frugal purchasers. But if low rates cause a constant seepage of physicians and plans from the system, state leaders may find that they have undermined the very system they created.

The forces driving increased medical costs make it imperative for governments to have a mechanism for controlling costs without jeopardizing access to quality care.

And what about the beneficiaries? How much have recent plan pullouts affected their care and what can they expect in the future? In the Medicare program, the number of beneficiaries that have been affected has been a relatively small percentage of the total. Many of the plan terminations were in rural areas where managed care enrollment and rates have been low. Most beneficiaries enrolled in plans that terminated had the option of joining another managed care plan, although that may have meant changing doctors. In California, for example, only 0.5% of beneficiaries, or about 6,600 people, were left without the option of joining a managed care plan.

Managed care plans originally used generous government premiums to add benefits such as prescription drug coverage and low out-of-pocket costs to attract beneficiaries. This resulted in rapid growth in enrollment. Plans' response to less generous premiums may be to decrease drug benefits and increase enrollee cost-sharing. Plans will attempt to do this while continuing to differentiate managed care from traditional Medicare and supplemental plans enough to appeal to beneficiaries. The outcome for enrollees in Medicare managed care is likely to increase out-of-pocket costs.

More information is needed to understand exactly what health plan exits from Medicare and Medicaid signal for future health plan decision-making, physician participation, and beneficiary care. The Medi-Cal Policy Institute, a project of the Foundation, has embarked on a study to examine the financial viability of health plans involved in the Medi-Cal program in order to understand how past performance may impact future behavior.

The forces driving increased medical costs make it imperative for governments to have a mechanism for controlling costs without jeopardizing access to quality care.

Managed care is the primary approach currently on the horizon that offers the possibility of achieving this goal. This creates a strong case for figuring out how to make it work for plans, physicians, the government and, most importantly, beneficiaries.

capsule

Affluence doesn't always improve survival. Adults with cancer do better if they are affluent, and there is some evidence that the same is true for children. An international team of researchers reports, however, that there is no socioeconomic gradient in children's survival from acute lymphocytic leukemia (*Archives of Disease in Childhood 1999;* 80:311-7). The researchers linked cancer registry data from England and Wales with measures of deprivation and found only a 3-6% difference in survival between socioeconomic groups—no more than would be expected by chance.